2017 Hot Topics in Home Health

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Session Type: Educational Sessions
Session Level: Intermediate

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Home Health Section
of the American Physical Therapy Association
CSM 2017:
Home Health
Hot Topics

Roshunda Drummond – Dye, JD
Cindy Krafft, PT, MS, HCS-O

Disclosure

• Speakers do not have any relationships that could reasonably be viewed as creating a conflict of interest, or the appearance of a conflict of interest, that might bias the content of the presentation.
Session Learning Objectives

• Connect the most current regulations to clinical practice in home health.
• Discuss the challenges and opportunities facing home health physical therapists.
• Develop strategies for long-term success in the postacute care arena.

First Up…..

• Roshunda Drummond-Dye
  – Director, Regulatory Affairs APTA
Value-based Payment

HHS Transition Timelines

- Alternative Payment Models
  - 30% of payments tied to alternative payment models by 2016; 50% by the end of 2018
- Linking Payment to Outcomes
  - 85% of fee for service payments tied to outcome measures by end of 2016; 90% by end of 2018

The Health Care Transformation Task Force

- 75% of payments into value-based models by January 2020
Shifting from Volume to Value

Changing Face of Payment

<table>
<thead>
<tr>
<th>Fee for Service</th>
<th>Pay for Reporting</th>
<th>Value-based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Volume of services</td>
<td>• Requires data submission to avoid penalty</td>
<td>• Benchmarking outcomes, quality measures</td>
</tr>
<tr>
<td>• No tie to outcomes</td>
<td>• No benchmarking</td>
<td>• +/-neutral/- payment adjustment</td>
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</table>

Alternative Payment Models

• *Not fee-for-service*
• Accountable care organizations
• Bundling of services
• Comprehensive Care Joint Replacement Model

What is an Alternative Payment Model (APM)?

APMs are new approaches to paying for medical care through Medicare that incentivize quality and value.

As defined by MACRA, APMs include:

- CMS Innovation Center model (under section 1332, other than a Health Care Innovation Award)
- MSSP (Medicare Shared Savings Program)
- Demonstration under the Health Care Quality Demonstration Program
- Demonstration required by federal law
Comprehensive Care for Joint Replacement Payment Model

CJR Model is focused on elective primary hip and knee replacement patients. Began April 1, 2016 and run for 5 years

Model includes inpatient stay and post discharge care 90 days after discharge

Unlike other innovative models, CJR requires that all IPPS hospitals in the selected MSAs must participate

The average Medicare payment for hip and knee procedures ranges from $16,500 to $33,000, according to the CMS

Medicare estimates a cost savings of $153 million over the 5 years of the model

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**What’s Included and Excluded in an Episode**

Example CJR Episode (MS-DRG 469, 470)

- **Included in Episode**
  - All care related to the episode with a discharge of MS-DRG 469 or 470
  - Medicare Part A and B (diagnostics 3 days prior to adm, procedure and stay, physician fees, inpatient rehab, HH, home health, PT, readmissions, outpatient services, IP psych, LTOH, part D drugs, hospice, amb/renal)
  - 90 day period for total episode spend

- **Excluded from Episode**
  - Unrelated hospital readmission and part B services
    - Specifically defined as unrelated acute and chronic surgical DRGs, and oncology and trauma medical DRGs
  - Inpatient IPPS new technology payment
  - Drugs outside episode (e.g., hernias, cloth, factors)

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Source: CMS, financial services sector analysis
Medicare Episode Payment Models

• CMS will run 3 new models similar to CJR to begin on July 1, 2017 and run for 5 years
• The models include 2 cardiac conditions: heart attacks and bypass surgery; and 1 orthopedic condition: hip/femur fractures
• All models would be mandatory in selected areas and would include inpatient stay and post discharge care 90 days after discharge

Future Episodic Models

Chronic conditions (diabetes, heart failure, rheumatoid arthritis)

Neurologic conditions (stroke, traumatic brain injury)

Degenerative conditions (Parkinson’s disease)

Other orthopedic conditions (spinal fusion)
Potential Issues with Overlapping Programs

- Hospitals participating in BPCI in the applicable MSA’s will not be required to participate in CJR.
- Hospitals participating in the Medicare Shared Savings Program (MSSP) can also participate in CJR.
- CJR reconciliation payments and repayments attributed to a specific episode may not be counted for in other models when determining cost of care.
- The CJR episode savings may not be achieved because the savings is paid back under the Shared Savings Program if the beneficiary is assigned to both models.
Compliance Checklist

* Who is the point person in your organization for review, questions or concerns?
* Do you have a written agreement with the hospital?
* What are the terms of the agreement and how long is the contractual obligation?
* Are you an affiliated provider or a collaborator?
* Is all payment tied to patient care, quality and outcomes?
* Are you performing duties outside of the normal Medicare rules? If so, is there an exception?
* Has the patient been informed of their right to choose?
* If you are a hospital, are payment distributions meeting the gainsharing exceptions? Are there any practices that compromise tax laws/charitable status?
* Make sure to reconcile claims internally and compare to CMS reports for errors in order to appeal if necessary.

Establish an Internal Audit Process for Optimal Performance

Home Health Pre-Claim Review Demonstration

• Administration Rationale –
  – Over 11,000 Home Health Agencies (HHAs) received more than $18 billion in Medicare payments in 2015
  – Out of that $18 billion in Medicare spending, CMS estimates that Medicare made more than $10 billion in improper payments
  – The HHS Office of the Inspector General and Department of Justice collected close to $1 billion in civil and criminal actions between 2011 and 2015 for claims paid under the Medicare home health benefit
Home Health Pre-Claim Review

• Beginning August 1, 2016, CMS launched a pre-claim review demonstration for home health agencies (HHAs) across 5 states.
• 3-year demonstration, CMS aims to lower the improper payment rate for home health services, which spiked drastically from 17.3% in 2013 to 59% in 2015.
• The demonstration will target HHAs in 5 high-risk states:
  – Illinois,
  – Florida,
  – Texas,
  – Michigan, and
  – Massachusetts

Home Health Pre-Claim Review

• HHAs must request a pre-claim review from their Medicare administrative contractor (MAC) for each episode of care. For each pre-claim review, HHAs must submit any clinical documentation needed to support the medical necessity and coverage requirements for home health services. HHAs may submit the pre-claim review requests and supporting documentation any time and as often as they like once the episode of care has started but before submitting the final claim for payment.

• A pre-claim review is required for all home health services, regardless of the number of visits required in an episode of care. Typically, in these settings, an episode of care lasts multiple weeks or months, so HHAs should have sufficient time to update their claims before they submit the final claim for payment.

• Compliance Tip: CMS has noted that HHAs often submit claims for services not provided, usually because they provide the same services to patients over a long period of time. HHAs should be sure to clearly document and review the services provided to Medicare patients before submitting claims for Medicare payment.
Home Health Pre-Claim Review

- Once a MAC receives the pre-claim review request, MACs will either provisionally affirm or not affirm claims based on the applicable regulations and coverage requirements. If the HHA submits enough documentation to support the claim, the MAC will provide a provisional affirmation. This means the claim will be paid as long as all other Medicare requirements are met and there is no evidence of potential fraud. When documentation is insufficient, the MAC will provide a non-affirming decision, meaning the claim does not meet medical necessity or coverage requirements, and the claim will be denied unless the necessary documentation is supplied to the MAC. MACs will aim to deliver decision letters to providers within 10 business days.

- Compliance Tip: If providers experience significant delays in MAC decisions on the pre-claim review, please keep us informed by emailing Advocacy@APTA.org

Home Health Pre-Claim Review

- Decision letters that do not affirm the pre-claim review will explain in detail which specific policy or requirement was not met. HHAs may resolve the issues described in the decision letter and provide additional documentation through resubmission. There is no limit on the number of resubmissions an HHA may make to satisfy the pre-claim review. Medicare contractors will aim to respond to resubmissions within 20 business days.

- During the first 3 months of the demonstration, claims submitted for payment without a pre-claim review will be delayed from payment until the pre-claim review is completed. But after the first 3 months of the demonstration, CMS will apply a 25% payment reduction to claims submitted without a pre-claim review (if the claim is payable). HHAs may not appeal the payment reduction, and they may not transfer this additional cost on to the beneficiary.
Home Health Pre-Claim Review

In week 24, which ended on January 14, 2017, the majority (88.5 percent) of pre-claim review requests received a fully affirmed decision. Overall in week 24, 91.7 percent of pre-claim review requests received a provisionally affirmed or partially affirmed decision.

IMPACT Act

Signed into law October 6, 2014
The Act requires the submission of standardized assessment data by:
- Long-Term Care Hospitals (LTCHs): LCDS
- Skilled Nursing Facilities (SNFs): MDS
- Home Health Agencies (HHAs): OASIS
- Inpatient Rehabilitation Facilities (IRFs): IRF-PAI

The Act requires that CMS make interoperable standardized patient assessment and quality measures data, and data on resource use and other measures to allow for the exchange of data among PAC and other providers to facilitate coordinated care and improved outcomes.
### PAC Settings: IMPACT Timeline

#### Quality Domains

<table>
<thead>
<tr>
<th>Quality Domains</th>
<th>HH A</th>
<th>SNF</th>
<th>IRF</th>
<th>LTCH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Functional Status</strong></td>
<td>1/1/2019</td>
<td>Percent of Patients or Residents with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)*</td>
<td>- Change in self-care score (NQF #2633)*</td>
<td>- Change in self-care score (NQF #2635)*</td>
</tr>
<tr>
<td><strong>Skin Integrity</strong></td>
<td></td>
<td>Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medication Reconciliation</strong></td>
<td></td>
<td>Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC)*</td>
<td></td>
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</tr>
<tr>
<td><strong>Major Falls</strong></td>
<td>1/1/2019</td>
<td>Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Preference</strong></td>
<td>1/1/2019</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
</tr>
</tbody>
</table>

* Based on CARE item set

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### PAC Settings: IMPACT Timeline

#### New Resource Use Measures

<table>
<thead>
<tr>
<th>Medicare spending per beneficiary</th>
<th>Claims-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge to community</td>
<td>Claims-based</td>
</tr>
<tr>
<td><strong>Hospitalization rates of potentially preventable readmissions</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program</td>
</tr>
<tr>
<td></td>
<td>- All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs (NQF #2502)</td>
</tr>
<tr>
<td></td>
<td>- Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF</td>
</tr>
<tr>
<td></td>
<td>- Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facilities</td>
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<tr>
<td></td>
<td>- All-Cause Unplanned Readmission Measure for 30-Days Post-Discharge from SNFs (NQF #2510)</td>
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<tr>
<td></td>
<td>- Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF</td>
</tr>
<tr>
<td></td>
<td>- Potentially Preventable 30-Day Post-Discharge Readmission Measure for Home Health (HH)</td>
</tr>
</tbody>
</table>
MedPAC Work on Unified Payment System

Must evaluate and recommend design of one PAC-PPS based on patient characteristics

Address considerations of replacement of existing PAC payment systems

Current plan is to build a bigger beta test off of PAC demo that included the CARE tool

Report due to Congress by June 30, 2016

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Overview of Mandate and Approach to the Analyses</th>
</tr>
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<tbody>
<tr>
<td>Mandate</td>
<td>Methodology</td>
</tr>
<tr>
<td>1. Evaluate and recommend features of a PAC PPS using data from the PAC-PRD</td>
<td>&quot;Full&quot; model uses data from PAC-PRD sample to predict relative costs of stays</td>
</tr>
<tr>
<td>2. Consider the impact of implementing a PAC PPS</td>
<td>&quot;Administrative&quot; model uses only existing data to predict relative costs of stays (in PAC-PRD sample)</td>
</tr>
<tr>
<td></td>
<td>&quot;Full&quot; and &quot;administrative&quot; models using the same PAC-PRD stays are compared</td>
</tr>
<tr>
<td></td>
<td>If accuracy is similar, use &quot;administrative&quot; model on 2013 PAC stays to estimate effects</td>
</tr>
</tbody>
</table>

Note: PAC = Postacute care; PPS = prospective payment system; PRD = Payment Reform Demonstration.
Conclusions by MedPAC on Unified Payment System Development

- A common unit of service and uniform adjustment method is feasible.
- The system can be risk-adjusted based on patient characteristics.
- A separate payment model is needed for therapy/services and ancillary services.
- Separate adjustment for HHAs to prevent overpayments.
- A common assessment tool will improve cost accuracy.
- Initial payments can be based on current practices and costs but need to transition value-based care.

Transition to PAC Unified Payment System

- Proposal to blend setting specific PPS and PAC PPS rates over multiple years:
  - Example of three year transition
    - 1st year: 1/3 PAC PPS rate and 2/3 setting specific rate
    - 2nd year: 2/3 PAC PPS rate; 1/3 setting specific rate
    - 3rd year: 100% PAC PPS rates
Up Next.....

• Cindy Krafft PT, MS, HCS-O
  – CEO Kornetti & Krafft Health Care Solutions
It Just Keeps Getting Better

Jimmo Update

• Federal Judge Ruling – filed Feb 2, 2017
  – “Confusion over the Improvement Standard persists,” wrote U.S. District Court Chief Judge Christina Reiss in Vermont
• CMS deadline to file an objection – Feb 16
• All measures MUST be completed by Sept 4
Settlement Details

1. CMS will disavow the application of the so-called "Improvement Standard" as improper under Medicare policy for the SNF, HH, and OPT benefits, while making clear that CMS has consistently denied the existence of such an "Improvement Standard."

2. CMS is willing, through counsel, to notify Plaintiffs and the court once the Technical Direction Letter and Health Plan Management System memorandum have been issued to, respectively, Medicare Administrative Contractors (MACs) and Medicare Advantage Organizations (MAOs).

Settlement Details

3. CMS will publish on its website cms.gov a new webpage dedicated to the Jimmo settlement. The Jimmo webpage will, in one location, provide access to public documents related to the settlement that have been previously posted on the cms.gov website.

4. CMS will post on the forthcoming Jimmo webpage one set of Frequently Asked Questions (FAQs). This document would be developed by CMS and would include multiple questions and answers regarding the policy clarification resulting from the Jimmo settlement.
Settlement Details

5. CMS will include a message regarding the Jimmo settlement when it announces the publication of the Jimmo webpage to providers, adjudicators, contractors, and other stakeholders.

6. CMS will clarify the responses in the document entitled "Summary of the questions posed and answers provided during the December 16, 2013 Jimmo vs. Sebelius National Call for contractors and adjudicators" to address the concerns identified by the court.

7. CMS will issue a Technical Direction Letter to MACs directing them to conduct, within a specified timeframe, additional training on the Jimmo manual clarifications. CMS would provide the MACs with materials for use in conducting this training.

8. CMS will issue a Health Plan Management System memorandum to MAOs requesting that they conduct, within a specified timeframe, additional training on the Jimmo manual clarifications. CMS would provide the MACs with materials for use in conducting this training.
Settlement Details

9. CMS will disavow the application of the so-called "Improvement Standard" as improper under Medicare policy for the SNF, HH, and OPT benefits, while making clear that CMS has consistently denied the existence of such an "Improvement Standard."

10. CMS is willing, through counsel, to notify Plaintiffs and the court once the Technical Direction Letter and Health Plan Management System memorandum have been issued to, respectively, Medicare Administrative Contractors (MACs) and Medicare Advantage Organizations (MAOs).

Corrective Statement

The Jimmo Settlement may reflect a change in practice for many providers, adjudicators, and contractors, who may have erroneously believed that the Medicare program pays for nursing and rehabilitation only when a beneficiary is expected to improve. The Settlement correctly implements the Medicare program's regulations governing maintenance nursing and rehabilitation in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and maintenance nursing and rehabilitation in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide. These regulations are set forth in the Medicare Benefit Policy Manual.
National Call

• Notice of the national call shall include the following statement: "This call will include corrective action mandated by the court overseeing the Jimmo settlement, clarifying the rejection of an improvement standard and explaining the maintenance coverage standard now included in the Medicare Beneficiary Policy Manual." Such notice will alleviate any potential confusion regarding the purpose of the national call.

Conditions of Participation

July 13
2017
Home Health Clinical Managers

• CMS expanded it’s the definition for home health clinical managers:
  – physical therapists and other licensed clinicians may be appointed to provide oversight of all patient care and services.

“Skilled” Professional Services

• Include physicians, skilled nurses, physical therapists, speech language pathologists, occupational therapists, and medical social workers.

• Services of “rehabilitation therapy assistants” must be “provided under the supervision of a physical therapist or occupational therapist.”
Additional Updates

• Protection of Private Patient Information
• Protection and Enforcement of Patient Rights
• Quality of Care

Patients’ Rights

✓ Notice of Rights
  ✓ Verbal on initial visit / written copy with contact info
✓ Exercise of Rights
✓ Explicit Home Health Patient Rights
✓ Patient Participation
  ✓ Informed / consent / refusal
✓ Investigation of Complaints
✓ Accessibility
Explicit Home Health Patient Rights

• Protection of property
• Protection of information
• Protection from abuse
• Assurance care plans are carried out
• Written notice of health care services and changes to plan of care

Quality of Care

• Expansion / clarification of requirements for a comprehensive assessment
  – Psychological and cognitive status
  – “Must” review care plan at least every 60 days
• Two NEW CoPs:
  – Care planning, coordination of services and quality of care
  – Quality Assessment and Performance Improvement (QAPI)
QAPI

• 5 Standards:
  – Program Scope
  – Data
  – Activities
  – Improvement Projects
  – Executive Responsibilities

HHGM

• Home
• Health
• Groupings
• Model
Why Change the Model

Examined costs associated with beneficiaries who were: low-income, lived in underserved areas, had high severity of illness

Report found current payment system produced lower margins for those needing parenteral nutrition
• with traumatic wounds or ulcers
• who required substantial assistance in bathing
• admitted to HH following an acute or post-acute stay
• who have a high Hierarchical Condition Category score
• who had certain poorly controlled clinical conditions
• who were dual eligible

What is Different?

Current Model
153 HHRGs
• Timing
• 3 clinical levels
• 3 functional levels
• 9 service use categories
  (number of therapy visits)

Proposed Model
28 HHGMs
• Timing
• Referral Source
• Clinical Grouping
• Functional Level
• Comorbidity Adjustment
Admission Source and Timing

- Community (No acute or post-cute care in the 14 days prior to the HH admission)
  - Early (first 30 day period in a sequence)
  - Late (second and later 30 day period in a sequence)
- Institutional (Acute or post-acute (skilled nursing facility, inpatient rehabilitation facility, long term care hospital) care in the 14 days prior to the HH admission)
  - Early (first 30 day period in a sequence)
  - Late (second and later 30 day period in a sequence)
30 Day Periods / 60 Day Episodes

• Days 1 up to 30
  – If applicable day 31 up to 60
  – Any 60 day episode 30 days or fewer will NOT get a second period
• Model would reduce/eliminate a need for RAPs. HHAs would bill

Clinical Grouping
Driven by primary diagnosis reported on claim

• Musculoskeletal Rehabilitation (10.9%)
• Neuro/Stroke Rehabilitation (8.2%)
• Wounds and Skin/Non-Surgical Wound Care (10.6%)
• Complex Nursing Interventions (3.5%)
• Behavioral Health Care (3.0%)
• Medication Management, Teaching and Assessment - “MMTA” (63.7%)
MMTA

• Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above groups

Functional Levels

• From OASIS Items (7 from 1800s and M1032)
  – Low
  – Medium
  – High
  
  M1800 Grooming Added
  Responses combined
Comorbidity Adjustment

- Defined as a medical condition coexisting in addition to the primary diagnosis and tied to worse health outcomes, more complex medical need and management and higher care costs.

- Periods having at least one comorbidity included with the adjustment group will receive an adjustment

HH Specific Comorbidity List

- heart disease
- respiratory disease
- circulatory disease
- cerebrovascular disease
- gastrointestinal disease
- neurological conditions
- endocrine disease

- neoplasms
- genitourinary/renal disease
- skin disease
- musculoskeletal disease
- behavioral health
- infectious diseases
HHGM Impacts by Clinical Group

- Wound and Complex Medical paid **MORE**
- MMTA paid **SAME**
- Neuro Rehab, MS Rehab and Behavioral Health paid **LESS**

HHGM Impacts

**Period Timing**
- Early episodes paid **MORE**
- Late episodes paid **LESS**

**Referral Source**
- Institutional Ref paid **MORE**
- Community Ref paid **LESS**
HHGM Impacts

Surgical Wounds
• No Known paid SAME
• Yes Known paid MORE

Parenteral Nutrition
• No parenteral paid SAME
• Yes parenteral paid MORE

Have Concerns?
Contact Abt Associates:
HomeHealth@abtassoc.com
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References

• Ruling Regarding Jimmo:
• Final CoPs in Federal Register:
• HHGM Technical Report: